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February 14, 2008

Honorable Henry A. Waxman, Chairman
The Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Chairman Waxman:

This is in response to the January 16, 2008 letter from your Committee requesting estimates of the effect of several CMS regulations proposed for Medicaid during the past year. The enclosed response is being submitted on behalf of me and David N. Sundwall, MD, Executive Director of the Utah Department of Health, who received the same request.

Thank you for giving us the opportunity to provide our comments and assessments on the effect of these regulations.

Sincerely,

Michael Hales

Michael Hales, Director
Health Care Financing

Enclosure.
c: David N. Sundwall, MD

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IMPACT OF PROPOSED CMS REGULATIONS ON THE UTAH MEDICAID PROGRAM

RESPONSE TO A REQUEST FROM
THE COMMITTEE ON
OVERSIGHT AND GOVERNMENT REFORM

U.S. HOUSE OF REPRESENTATIVES

FEBRUARY 12, 2008

Executive Summary

Proposed Rules Impact on Utah Medicaid

Proposed Rule	Estimated 5-Year Impact
Cost Limits for Public Providers (CMS 2258-FC)	$216,085,481
Payments for Graduate Medical Education (CMS 2279-P)	$102,734,432
Medicaid Program: Health Care-Related Taxes (CMS 2275-P)	None
Payment of Hospital Outpatient Services (CMS 2213-P)	None
Coverage of Rehabilitative Services (CMS 2261-P)	$13,028,603
Payments for Costs of School Administrative and Transportation Services (CMS 2287-P)	$13,540,806
Targeted Case Management (CMS 2237-IFC)	$15,415,789
Total	**$360,805,111**

Cost Limits for Public Providers (CMS 2258-FC)

This rule limits Medicaid reimbursement for health care providers that are operated by units of government to an amount that does not exceed the health care provider's cost of providing services to Medicaid individuals. It also limits reimbursements for privately operated facilities to that amount that would be paid by Medicare for similar services. The rule makes provision for how costs are to be measured.

The impacted hospitals in Utah include one large urban teaching hospital (University Hospital) and several small rural hospitals. This rule will impose different reimbursement methodologies for public versus private providers. While the dollars for rural hospitals are relatively small, the impact on these facilities may put some of them at risk for closure if local governments will not provide further subsidies. Rural providers going out of business could cause access to care problems. Utah, being a low DSH state, cannot totally alleviate this problem through disproportionate share payments.

Estimated Five-Year Impact on State:

Utah public hospitals would experience the following estimated reductions in federal Medicaid funds for the next five years:

Fiscal Year	Total
2009	$40,700,688
2010	$41,921,709
2011	$43,179,360
2012	$44,474,741
2013	$45,808,983
Total	**$216,085,481**

Payments for Graduate Medical Education (CMS 2279-P)

This proposed rule would clarify that costs and payments associated with Graduate Medical Education (GME) programs are not expenditures for medical assistance that are federally reimbursable under the Medicaid program.

The affected Utah hospitals include one large urban teaching hospital (University Hospital) and other participating teaching hospitals. This reduction in federal GME payments may further exacerbate the physician shortage in Utah.

Estimated Five-Year Impact on State:

Utah hospitals would experience the following estimated reductions in federal Medicaid funds for the next five years:

Fiscal Year	Amount
2009	$19,350,500
2010	$19,931,015
2011	$20,528,945
2012	$21,144,814
2013	$21,779,158
Total	**$102,734,432**

Medicaid Program: Health Care-Related Taxes (CMS 2275-P)

This proposed rule would revise the threshold under the indirect guarantee hold harmless arrangement test to reflect the provisions of the Tax Relief and Health Care Act of 2006. It provides that, when determining whether there is an indirect guarantee under the 2-prong test for any part of a fiscal year on or after January 1, 2008 through September 30, 2011, the allowable amount that can be collected from a health care-related tax is reduced from 6 to 5.5 percent of net patient revenues received by the taxpayers (providers).

Utah currently applies a provider tax to two classes of health care services—nursing facility services and Intermediate Care Facilities/Mentally Retarded (ICF/MR) services. Neither of the services is taxed in excess of the proposed 5.5 percent threshold.

Estimated Five-Year Impact on State:

The state does not anticipate a significant reduction in federal Medicaid funds to our state or any effect on Medicaid recipients due to this rule.

Payment of Hospital Outpatient Services (CMS 2213-P)

This proposed rule would amend the regulatory definition of outpatient hospital services for the Medicaid program. Outpatient Hospital services are a mandatory part of the standard Medicaid benefit package. The current regulatory definition at 42 CFR 440.20 is broader than the definition in Medicare, and can overlap with other covered benefit categories. The purpose of the amendment is to align the Medicaid definition more closely to the Medicare definition in order to improve the functionality of the applicable upper payment limits (UPL) under 42CFR 447.321 (which are based on a comparison to Medicare payments for the same services), provide more transparency in determining available coverage in any state, and generally clarify the scope of services for which federal financial participation (FFP) is available under the outpatient hospital services benefit category.

Utah has determined that the proposed rule will have little impact on the state. The current Utah Medicaid State plan does not include any non-hospital services as part of the covered outpatient hospital service benefit, and thus conforms to the proposed rule. Further, the Utah outpatient hospital UPL calculation methodology is in concert with the methodology being proposed by CMS and does not include non-hospital services in the calculation.

Estimated Five-Year Impact on State:

We project Utah payments for outpatient hospital services will be under the UPL for the foreseeable future. The state does not anticipate a significant reduction in federal Medicaid funds to our state or any effect on Medicaid recipients due to this rule.

Coverage of Rehabilitative Services (CMS 2261-P)

The changes to the Medicaid rehabilitation rule as proposed by CMS, specifies that rehabilitative services must result in a "measurable reduction of disability and restoration of functional level." The preamble to the proposed rule clearly identifies rehabilitative services as non-custodial and although it gives ostensible support to the fact that rehabilitation goals are often contingent on the individual's maintenance of a current level of functioning, it ultimately invalidates services provided primarily in order to maintain a level of functioning in the absence of progress toward a rehabilitation goal.

Such a perspective could seriously impact the seriously and persistently mentally ill (SPMI) consumer population who characteristically are long in service duration and slow in rehabilitative progress. One likely casualty of the maintenance limitation could involve symptom maintenance through medication management. Medication management of symptomatology is not synonymous with reduction of disability and restoration of functional level with respect to the bio-psycho-social complexities associated with serious and persistent mental disorders. Public mental health providers have a significant share of SPMI consumers for whom medication management may be the primary, if not the exclusive rehabilitative service modality. Through effective symptom management many such consumers who previously spent years in State hospitals or cycled repeatedly through acute inpatient settings have been able to maintain institutional independence, usually with the aid of non-rehabilitative approaches such as case management, personal service, and supportive living supports, often in lieu of psychotherapy and other defined rehabilitative methodologies. However, even with such compliments of service, both disability and functional level of the SPMI consumer often plateau for significant periods of time without either demonstration of measurable reduction in disability or restoration of functional level. Still, the value of "maintenance" that allows the individual to avoid institutional care and gain tenure in less restrictive community settings can certainly be argued as a measure of success in and of itself, although there is considerable risk in the proposed rule that such may be viewed within a custodial and therefore non-rehabilitative context.

If the Medicaid rehabilitation rule is finalized as proposed, there is concern that exclusive medication management services could be interpreted as a maintenance or custodial benefit and could therefore become vulnerable to a denial of coverage. Unfortunately, this would have a compounding effect on assessment, case management, and other services that are delivered in direct support of pharmacotherapy. Such an outcome, we predict, would result in higher rates of inpatient care and institutional utilization, with untold costs to both consumer and system alike.

Estimated Five-Year Impact on State:

Fiscal Year	Amount
2008	$2,405,448
2009*	$2,501,666
2010*	$2,601,732
2011*	$2,705,801
2012*	$2,814,033
Total	**$13,028,603**

*MCPI 4%

Payments for Costs of School Administrative and Transportation Services (CMS 2287-P)

Under the Medicaid program, Federal payment is available for the costs of administrative activities "as found necessary by the Secretary for the proper and efficient administration of the State plan." This final rule eliminates Federal Medicaid payment for the costs of certain school-based administrative and transportation activities because the Secretary has found that these activities are not necessary for the proper and efficient administration of the Medicaid State plan and are not within the definition of the optional transportation benefit. Based on these determinations, under this final rule, Federal Medicaid payments will no longer be available for administrative activities performed by school employees or contractors, or anyone under the control of a public or private educational institution, and for transportation from home to school. Utah does not receive Medicaid funds for transportation activities. Under the new rule Utah will lose all Medicaid funds paid to school districts for administrative activities necessary for the delivery of Medicaid services to children. The loss of Medicaid administrative funds means the school districts must absorb the administrative cost incurred in delivering Medicaid services to students.

Estimated Five-Year Impact on State:

Fiscal Year	Amount
2008	$2,500,000
2009*	$2,600,000
2010*	$2,704,000
2011*	$2,812,160
2012*	$2,924,646
Total	**$13,540,806**

*MCPI 4%

Targeted Case Management (CMS 2237-IFC)

The Interim Final Rule goes beyond DRA intent which was to "insert clarity as to what is an appropriate TCM service under Medicaid, and therefore appropriately claimed under Medicaid, and what is not." [1]

Rather than addressing the TCM issue as intended, the rule makes far-reaching changes to all aspects of case management services under Medicaid including:

- **Right of Refusal §441.19(a)(3)** The Rule includes a requirement that states cannot compel an individual to receive case management services. However, states are required to make specific assurance to CMS with regard to HCBS Waivers. Many of the assurances require the participation of the waiver case manager as an integral component of continuously meeting the assurances. At the point HCBS waiver recipients can opt out of having a case manager, the HCBS waiver cannot meet the assurance of appropriate care plan development, health and safety of the client, assure service providers are competent and providing services in compliance with care plan, etc. In addition, this provision will present serious barriers to the state's ability to provide quality and cost-effective waiver services.

- **Single Case Worker Requirement §441.18(a)(5)** The rule would require Medicaid case management services be provided by a single case manager. The rule implies that if case management services are provided by more than one entity, this equates to a duplicate payment for the same service. Utah agrees that duplicate payment should not be made for the same service but strongly disagrees with the CMS interpretation that services provided by more than one CM provider implies the provision of the "same service" Case Managers with expertise in the arena of HCBS services are coordinating care and services within the realm of their expertise, while a mental health case manager for example would be coordinating services within their area of expertise. These activities are distinct and are not duplicative of the other and should therefore be permitted. Without the ability to utilize case managers having a specific area of expertise, the client will be required to choose a "generalist" case manager. Utah is concerned that this requirement will reduce the effectiveness of the case management service because, the individual will no longer be served by experts and may therefore miss the opportunity to be connected with the appropriate services of which the "generalist" may not be aware.

[1] Excerpt from an April 5, 2006 letter to HHS Secretary Michael Leavitt, from the DRA provision's author, Senator Charles Grassley (R-IA), then Chairman of the Senate Finance Committee

- **Eliminating Administrative Case Management (CM) §441.18(c)(5)** The Rule requires states to convert administrative case management service over to a service (FMAP funding).

    - Two of Utah's six Home and Community Based Waiver Programs currently utilize administrative case management. Both the programs serve highly complex populations in which CM is provided by specialized registered nurses who are trained and employed by state agencies (Children with Special Health Care Needs and Services for People with Disabilities). It is not clear which, if any, individual components of case management can be claimed as administrative functions. Under the Rule, both Utah's waivers will be required to amend the programs significantly; thus, potentially requiring Utah to contract with any willing provider for this specialized service. The training and monitoring to assure quality of a number of new providers will be an onerous and unnecessary administrative expense and will only further fragment access to services.

- **Definition of Case Management for Transition §440.169** The Rule changes allow for billing of CM for 60 days and in some cases only 14 days prior to discharge. This provision is extremely problematic for HCBS waivers that have a specific intent of moving clients out of facilities back into the community. **SMD Letter #01-006 Olmstead Update No: 4, Letter Number 3, Date: January 10, 2001** explicitly permits states to bill for case management services for individuals transitioning from institutional care to HCBS Waivers- up to 180 days prior to deinstitutionalization. The SMDL recognizes the complexity and difficulty in transitioning individuals and was consistent with Olmstead and the philosophy of supporting transitioning clients from institutions back into the community. Utah has one HCBS waiver whose target population is individuals residing in nursing facilities. The Rule does not recognize the intricacies involved with finding appropriate residential and other living arrangements for a person who has lost all their community resources due to residing in an institution for several years. The Rule is inconsistent with and contrary to initiatives to support community based living. In Utah, it will prevent some individuals with the potential for community living from doing so because the case manager may be unable to do the needed discharge planning in the 60 day time frame rather than the 180 days that had been permitted previously.

Estimated Five-Year Impact on State:

It is difficult to predict the estimated reduction in federal Medicaid funds. The original estimated savings of this section of the Deficit Reduction Act was estimated by the Congressional Budget Office to reduce total federal spending by $760 million over the following five-year period, but CMS is stating that the Rule will result in a reduction of $1.28 billion over the five-year period. Utah remains unclear what distinct aspects of case management will continue to be eligible for FFP, but has estimated reductions based upon our reading of the Rule.

Fiscal Year	**Amount**
2008	$2,846,174
2009*	$2,960,021
2010*	$3,078,422
2011*	$3,201,559
2012*	$3,329,621
Total	**$15,415,789**

*MCPI 4%